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ABSTRACT

Designing therapeutic approaches for language-disordered young children calls for the coordination of communication skills across the three developmental pathways: motor, social-emotional, and language-cognitive. The case study presented in this document examines the effectiveness of a dance-movement therapy intervention conducted over a 2-year period with a severely language-disordered young child. Alex was diagnosed with infantile autism at age 18 months. Dance movement therapy was begun at the age of 2.5 years, with the initial goals of increasing body awareness and reducing body tension in the service of communication. Dance movement therapy was selected because it was believed that children build a foundation for social expression based upon early nonverbal movement patterns. After a 6-month period of poor progress, an intervention combining both individual and dyad dance movement therapy was administered, with the goal of increasing both the frequency and duration of nonverbal interactional behavior. It was felt that the child-child dyad could best facilitate functional nonverbal communication. Alex subsequently experienced a tremendous leap in development, in which he maintained eye contact, participated in nonverbal turn taking routines, and responded appropriately to questions. Includes five references. (JDD)

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A Nonverbal Intervention for the Severely Language Disordered Young Child: An Intensive Approach

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- An Intensive Approach

One can think of many daily life instances in which there is much "talk", but little communication. These pragmatic or social communication features of language are especially difficult for the language disordered child. In fact, the language disordered child may provide the dramatic illustration of the importance of communication in language. When designing therapeutic approaches for language disordered young children, it becomes essential to focus upon the normal coordination of communication skill across the three developmental pathways: motor, social-emotional, and language-cognitive. This analysis applies for all children for whom functional language must be taught. There is no point in teaching language disordered individuals to talk, if this talking is not imbedded in communication skill.

Communication can be achieved in many different ways. Systematic communication of intentions and meanings are found in sign language, as well as speech. But less formalized behaviors, such as gestures, eye movements, and facial expressions also possess communication intent. Nonverbal signals are crucial to early communicational exchange. Ricks and Wing (1975) have observed that severely language disordered children are limited in the use of nonverbal, as well as verbal communication. These nonspeech skills can often emerge through the intensive nonverbal intervention that includes, but is not limited to the use of dance movement therapy. This case study examines the effectiveness of a dance-

movement therapy intervention conducted over a two year period with one severely language disordered young child enrolled in a therapeutic nursery for young language disordered children.

Relevant Theoretical Perspectives: Why Use Dance-Movement Therapy with The Language Disordered

Definition:

Dance-Movement therapy is the therapeutic use of movement as a primary modality in the treatment of disordered individuals. Movement may be used to enhance cognitive, emotional, or social development. In the case of the language disordered child, movement is obviously used to develop social communication skills. When the child can recognize and appropriately respond to the nonverbal signals that accompany language, then meaningful verbal interaction is more likely to follow.

Unlike occupational therapy, which is predominantly developmental in its approach, dance movement therapy is rooted in two theoretical models: developmental and psychodynamic. Simple stated, the developmental paradigm is grounded in the ontogenetic principles of growth and maturation, a process which begins at birth. Treatment is directed to remediating specific developmental deficits to stimulate more functional patterns of movement and behavior. In contrast, the psychodynamic focus addresses psychosocial

issues of communication and interaction (Whitehouse, 1979). When addressing both the developmental and social deficits characteristic of language disorders, it becomes useful to synthesize these two approaches.

We live in an almost totally verbalized society, with contant acceleration toward this direction by the media. It is perhaps difficult, in a culture that believes everything can be solved by discussion, to understand the plight of those whose expression lies below the level of talk. Before children are able to utter a single word, their emotions and ideas are experienced, expressed, and perceived through the use of bodily movement and gesture. Movement, then, is communication, although nonverbal, and it is vital that early childhood professionals understand this earliest form of language and all its motor manifestations (Espenak, 1981). In the syndromes associated with language disorder one, is often confronted, by withdrawal, a constellation of bizarre, highly stylized, and unique personal mannerisms, and by an intensely personal world where comprehension and communication are more or less blocked to normal means of interpersonal access. Yet dance or movement offers a particularly appropriate modality for therapeutic intervention in the case of children with severe language and communication disorders. The dance movement therapist uses the communication symptoms themselves to draw the child into a therapeutic relationship. This is often accomplished by imitating the child's movements to establish rapport with his movement language. Using such techniques as moving with the child, joining his movements, and exploring space, distance, nearness, and direction in harmony

with his, the therapist's intervention represents a very practical application of social/pragmatic theory as advocated by Bruner (1975).

Some communication failures of language disordered children may be due to their inability to be cued by subtle social stimuli (Bruner, 1975). Socially appropriate behavior requires an ability to engage in and redirect social behavior. Language disordered children typically behave in ways that are socially inappropriate. They tend to flip their fingers, rock, engage in excessive nonsense talk, and so on, despite clear signs of social disapproval. Normally, children learn that talking loudly, laughing, giggling, or masturbation are tolerated in certain contexts but not in others. Self-stimulatory behaviors are not unique to language disordered persons; we merely discriminate between those conditions in which they are appropriate and those in which they are not.

By accepting the language disordered child's movements as appropriate and responding to them in a reciprocal fashion, the dance movement therapist gives the child's gesture meaning. The child's once totally self-absorbed behavior now has been given communicative intent. Children learn language concepts, not simply by their own initiations, but by how individuals respond to them.

Background Information

At age 18 months, Alex had been clinically diagnosed with infantile autism, a severe language disorder, by a licensed clinical psychologist. At that time psychological intervention in the form of play therapy was introduced. However, parents were dissatisfied with this particular intervention and this concern resulted in their search for an alternate treatment. At 2 years 5 months, Alex was referred by a neurologist to the School for Language and Communication Development for an initial speech/language evaluation. Alex was accompanied to this evaluation by his mother, a registered nurse, and his father, a physician.

Alex's mother reported that he was the result of an unremarkable second pregnancy culminating in a Caesarean section delivery due to "failure to progress." The first pregnancy had terminated in miscarriage. Alex had contracted chicken pox at 6 weeks of age, and had had two ear infections during his first year, which responded to antibiotic treatment. Alex sat at seven months, crawled at nine, and walked at 18 months. He was not yet toilet trained at the time of this interview. Alex responded to sound at one month and started to babble at five. He began using single word utterances at 26 months. Informal observation revealed that Alex appeared to follow auditory stimuli presented at the level of conversational speech. A complete audiological evaluation conducted subsequent to this interview indicated that Alex's hearing was within normal range.

Language Evaluation

Alex came willingly to the diagnostic room with his parents but was unavailable for formal diagnostic language procedure. Information regarding language functioning was obtained via informal observations during play activities and administration of the Receptive-Expressive Language Emergent Scale in conjunction with the parent interview.

Throughout the evaluation, Alex demonstrated appropriate eye gaze for objects but not for people. Communication took the form of non-linguistic vocalizations in conjunction with gestures. Parents revealed that Alex was able to regulate the behavior of others at home via gestures and single word utterances.

Cognitively, Alex demonstrated knowledge of object permanence by looking for a hidden ball and exhibited problem solving skills in reconstructing a ring stack toy. He did not demonstrate any representational or symbolic play behaviors during this evaluating session. He was able to code and demonstrated the spatial concepts of "in," "on," and "under." He did not respond to directives by the examiner but was reported to follow directives by his parents at home. Alex's vocalizations during the evaluation were entirely non-linguistic.

Clinical impressions from the examiner diagnosed a child with a severe comprehension and production language disorder of unknown etiology characterized by a limited phonemic repertoire and a primarily gestural means of communication. It was also noted that Alex's intellectual functioning appeared precocious when compared to his limited social skill. Recommendations were for placement at the School for Language and Communication Development, (SLCD) a therapeutic nursery for young language disordered children and a complete dance movement therapy evaluation, to ascertain his need for individual therapy.

Dance-Movement Therapy Evaluation

The initial dance/movement therapy evaluation was performed one month after the speech and language assessment. The consensus of this report, which consists of detailed informal observations from the examining dance movement therapist, concurred with that of the language evaluation. Alex presented as a child with severe pragmatic and social difficulties. He did not respond to verbal prompts, communicative intent was poor, and verbal language was non-existent. Nonverbal cues, such as eye contact and gesturing were observed but were infrequent, and often inappropriate. Alex exhibited a high body tension which appeared to interfere with his movement in an around objects and people. He did not respond to his mirror image and was unable to identify parts of his body when directed by the therapist. Recommendations were to initiate individual dance movement therapy twice a week.

The initial goal of therapy was to increase body awareness and reduce body tension in the service of communication:

First Year of Treatment

Alex was wait listed for the SLCD program and accepted two months later. He was placed in a classroom of 5 other language impaired children, 1 certified speech language pathologist and 2 teaching aides. Alex received the stated individual dance movement intervention for the prescribed 2x per week, with the same therapist who had conducted the initial dance/movement evaluation.

At the same time, Alex's parents were involved in a comprehensive parent education and peer support program at the school placement. They were receptive and responsible in networking with Alex's teachers and therapist and had reliably implemented therapy techniques at home. Nonetheless, Alex's progress during the next 6 months was poor and his availability for classroom experiences was limited to exploration of objects, an activity that remained unchanged from earlier observations.

That summer, a transdisciplinary team of professionals met to discuss Alex and other children with limited progress and possible intervention alternatives. As the assistant director of the program, I chaired those meetings and consolidated recommendations. A videotape used to assess Alex's social functioning was presented for review during that meeting. Here Alex then 3 years 2 months, was in a small group with his therapist, his classroom aide, and 2 classmates.

Professionals noted Alex's lack of interaction, eye contact, vocalization, gesture, proximity, and inappropriate facial expression. In addition, Alex's lack of interaction seemed to perpetuate itself in the attitude of adults and children who directed their attention to other persons rather than to the self absorbed Alex. Not only was Alex non interactive, but after a period of 6 months he had shaped his environment to be non interactive as well.

Based upon a number of like tapes and informal observations of Alex, the following intervention as developed. This intervention combined both individual and dyad (2 child members) dance movement therapy sessions administered for one year period for three 30 minute sessions per week; one individual session; two dyad. All sessions were conducted by the same dance movement therapist. In Alex's case, this professional was to be new, as his initial therapist was taking a new position in a different facility.

Dance movement therapy was selected as the primary vehicle in this intervention as it was believed that children build a foundation for social expression based upon early nonverbal movement patterns. It was felt that the dyad, as the primary social unit of communication, could best facilitate functional nonverbal communication. During the individual sessions the therapist would facilitate adult-child nonverbal interactions; in the dyad, child-child nonverbal interaction. Once these nonverbal concommittants of spoken language were in place, it was hypothesized that functional verbal behavior would follow. Alex's dyad partner was a classmate, with a communication disorder of a different nature than Alex's. He was selected as Alex's partner because his communication behavior was considered intrusive and somewhat demanding. Alex would have difficulty avoiding attention to him.

The initial goal of this intervention was simple and direct: to increase both the frequency and duration of nonverbal interactional behavior. The therapist involved was not specifically directed in her choice of activities or materials chosen to stimulate interactional behavior However, quite naturally, certain play activities involving climbing and sliding on platforms and crawling in and out of tunnels in "peek-a-boo" style evolved. These activities helped to facilitate nonverbal interaction.

After three months of intervention in the dyad, Alex began to demonstrate a visual regard of people, increased vocalizations, a new tolerance of persons, and the presence of early linguistic forms, such as "ball" and "up".

Second Year of Treatment

During the commencement of the second year of dyad intervention, Alex experienced a tremendous leap in development. He was now 3 1/2 years old. Alex was able to establish and maintain eye contact during interpersonal exchanges, and participate in nonverbal turntaking routines. The nonverbal and verbal behaviors of request, calling attention, and protest were all being exhibited in some consistency. Semantically, Alex began to respond inconsistently, but appropriately at times, to "what" and "who" questions. With adult models, he was also responding more appropriately to yes/no questions.

During the ensuing 4 months, Alex continued to progress though more gradually. Although most of his play interactions were observed to be for the lack of a better term, at the level of parallel play, Alex was beginning to demonstrate specific peer related behavior during dyad sessions.

Discussion:

Much research on young children with handicapping conditions has indicated that if the critical fixed behavior pattern periods are not taken advantage of, the impaired child may not develop as fully as he or she might, owing not to the handicap but to the failure of the environment to provide substitute experiences.

Aslin, (1981) has proposed 5 types of experiences that have a potential influence on development.

1. Maturation - systems so genetically predetermined as to follow their genetic course in the absence of experience. (ie. sexual maturation).

2. Maintenance - those systems maintained only with experience. (ie. animals with normal vision appear blind if raised in darkness until visual tract is mature).

3. Facilitating- experiences that tend to accelerate development. (ie. highly verbal mothers tend to have children who acquire larger vocabularies at an earlier age).

4. Attunement- experiences that carry a skill to a higher level than through ordinary facilitation (ie. children learn fundamental scientific concepts through self discovery. However, understanding of advanced scientific concepts may not develop without specific instruction).

5. Induction- experiences that assist in producing skills that the individual may not acquire unless the environment provides the opportunity (painting, playing the violin). Inductive experiences may relate to providing instruction for the development of human intelligences that do not appear automatically through prewired genetic programming.

The hypothesis is that for the language disordered child ordinary facilitative experiences that mothers provide as preverbal social exchanges for their infants (ie. rocking back and forth while singing, "catch-me, catch-me" games, tickling toes, "peek-a-boo", jumping on the bed, hide and seek) become attunement or induction experiences for the impaired child. Rather than being absorbed through the environment, as incidental learning, social experiences need to be presented directly to the impaired child as a kind of instruction. These were the kinds of experiences the dance-movement therapist presented during her individual and dyad sessions. Byh reinforcing and repeating these early nonverbal developmental games, the dance-movement therapist sets the occasion for interaction, just as the mother does for her baby.

Conclusion

At the conclusion of his second year of dyad intervention Alex continues to present with a severe comprehension and production disorder. Recent psychological testing reveals a child within the 40th percentile with regard to intellectual functions. Alex still requires maximal prompting to consistently participate in peer related activities. Even so, this is a vast improvement in expectation for the child whose diagnosis originally included infantile autism. Alex no longer has the sigma of that label. Recommendations are to continue his therapeutic special education placement and dyad intervention.

Communication is the major goal in dance movement therapy. Since all communication, whether verbal or gestural, is directed toward someone, movement has the aim, among its other aims, of making contact with another human being. This is defined as the relationship maintaining function of language. The language of movement is human contact. This contact may be easier for some to establish than the sole reliance upon direct verbalization. One of the major functions of movement or dance historically has been to create unity with other persons. We cannot and should not isolate the verbal from the nonverbal experience. The basis of our function as social beings may lie in our earliest nonverbal expressions. The story of Alex has chosen to illustrate this belief.

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